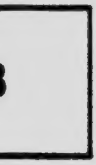

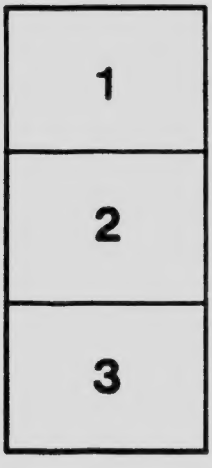

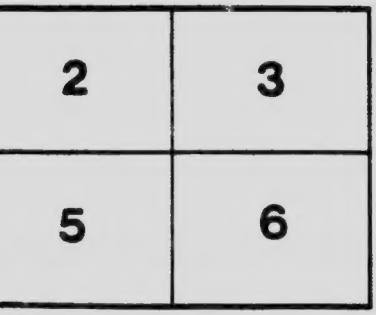

NOTE ON A RAPID METHOD OF DIAGNOSIS IN LEPROSY.

By Francis J. Shepherd, M.D., of Montreal.

Read before the twenty-seventh annual meeting of the American Dermatological Association, Washington, D. C., May 12, 13 and 14, 1903.

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CASE: The patient, a Chinese laundryman, *æt.* 19, named Hum Sam, was admitted into the Montreal General Hospital, April 17, 1902. He left China two years ago and has lived in Montreal ever since. Until September, 1901, was quite well. At this time there was redness and thickening of the skin on the forehead. This was soon followed by erythematous patches on the arms. This eruption was very itchy; was much worse in warm weather and cold seemed to improve it. From thence it extended over the body.

The patient is a well-made young man, of fair intelligence. On the forehead are seen reddened areas of thickened skin from the size of a 20-cent piece to a 50-cent piece. Some of these patches are fused together; there are also similar patches on the face, on cheeks and temples. These patches are not painful, but are very itchy at times. On the arms, especially on the exterior surfaces of the elbows, are round and oval areas, covered with small whitish scales. The scales are more at the margins of these patches, the center being of smoother appearance and brownish yellow in color. These areas are distinctly anæsthetic, some more so than others. Similar patches are seen on the trunk and legs, but these are not so numerous as on the arms. The patches are raised above the surrounding skin and are all covered with branny scales of a yellow-brown color. They are especially well marked on the buttocks, where they have somewhat the appearance of an old psoriasis.

Both external jugular veins are easily felt, and seem to have much thickened walls, which make them feel like cords. There is no tenderness on pressure. The glands in the posterior cervical triangle behind the sterno-mastoid are much enlarged. The inguinal and epitrochlear glands are increased in size. The hands are perfectly free from nodules and are apparently normal.

Both ulnar nerves behind the elbow are distinctly thickened and nodular, especially on the left side. The musculo-spiral nerve is also slightly enlarged. There is also some enlargement of the external popliteal nerves at the knee joints.

It was very difficult to get any information out of the patient, even through an interpreter, chiefly because it was not given willingly,

It was important to make an accurate diagnosis, as the city authorities wished to have the man sent back to China if the case were positively one of leprosy, the Canadian Pacific Railway having agreed to transport him free of charge. So I decided, to make the diagnosis sure, to cut down and remove a portion of one of the ulnar nerves. This was done and a nodule removed. Dr. J. McCrae, our Pathologist, examined the nodule and without trouble found numbers of the leprosy bacilli, which, of course, definitely established the diagnosis.

DISCUSSION.

Dr. Frank H. Montgomery said that Dr. Hyde and he recently had their attention called by Dr. Z. F. Barker to the early involvement of the great auricular nerve in leprosy. Professor Baelz, of Tokio, Japan, found that this nerve was involved in 90 per cent. of all cases of anæsthetic leprosy, and much earlier than the ulnar nerve. The nerve was easily accessible and its involvement was readily detected. In a case of anæsthetic leprosy which came under Dr. Hyde's observation three months ago, in which there were but few symptoms, the auricular nerve was found to be as large as an ordinary lead pencil, while the ulnar nerve was but slightly enlarged.

Dr. P. A. Morrow thought that in a case where the clinical symptoms were as pronounced and as characteristic as in the case reported by Dr. Shepherd, the bacteriological confirmation of the diagnosis was scarcely necessary. About sixteen years ago he recalled seeing a similar case of anæsthetic leprosy in which he had suggested a similar procedure, but in that instance the symptoms were asymmetrical and not at all characteristic, excepting in the right lower extremity.

At the last meeting of the New York Dermatological Society, Dr. Mewborn exhibited some slides showing the lepra bacillus obtained from the nasal secretions. He was somewhat interested in this line of experiments, because he believed that the nose was the primary seat of the localization of leprosy, and as he was the first one to announce this, he had been surprised that the profession in this country had paid no attention to it until the appearance of Jeanselme's work, which rather confirmed bacteriologically what he had claimed existed upon a clearly clinical basis. In a very large proportion of these cases, the identification of the lepra bacillus in the nasal secretions, could be very easily made. It had been his custom in quite a number of cases which had come under his observation during the past three or four years to apply this test, and he thought it had seldom failed.

Dr. S. Pollitzer: While the confirmation of finding the lepra bacilli in a bit of the excised nerve was final, he would like to ask Dr. Shep-

herd what he would have done in a case in which the clinical symptoms were clear, as in the case described, had he not found the bacilli?

Dr. SHEPHERD knew of the fact mentioned by Dr. Morrow, but in the case reported there was absolutely no nasal secretion.

He expected to find the lepra bacillus in the excised portion of the nerve, and was not disappointed.